(4) If applicable, the new lower level of care being covered in the hospital setting; and

(5) Any additional information specified by CMS.

[68 FR 16667, Apr. 4, 2003, as amended at 70 FR 4740, Jan. 28, 2005]

EFFECTIVE DATE NOTE: At 68 FR 20349, Apr. 4, 2003, § 422.620 was revised. This section contains information collection and recordkeeping requirements and will not become effective until approval has been given by the Office of Management and Budget

§ 422.622 Requesting immediate QIO review of noncoverage of inpatient hospital care.

(a) *Enrollee's right to review or reconsideration.* (1) An enrollee who wishes to appeal a determination by an MA organization or hospital that inpatient care is no longer necessary must request immediate QIO review of the determination in accordance with paragraph (b) of this section. An enrollee who requests immediate QIO review may remain in the hospital with no additional financial liability as specified in paragraph (c) of this section.

(2) An enrollee who fails to request immediate QIO review in accordance with the procedures in paragraph (b) of this section may request expedited reconsideration by the MA organization as described in § 422.584, but the financial liability rules of paragraph (c) of this section do not apply.

(b) *Procedures enrollee must follow.* For the immediate QIO review process, the following rules apply:

(1) The enrollee must submit the request for immediate review—

(i) To the QIO that has an agreement with the hospital under parts 476 and 478 of this chapter.

(ii) In writing or by telephone; and

(iii) By noon of the first working day after he or she receives written notice that the MA organization or hospital has determined that the hospital stay is no longer necessary.

(2) On the date it receives the enrollee's request, the QIO must notify the MA organization that the enrollee has filed a request for immediate review.

(3) The MA organization must supply any information that the QIO requires to conduct its review and must make it available, by phone or in writing, by the close of business of the first full working day immediately following the day the enrollee submits the request for review.

(4) In response to a request from the MA organization, the hospital must submit medical records and other pertinent information to the QIO by close of business of the first full working day immediately following the day the organization makes its request.

(5) The QIO must solicit the views of the enrollee who requested the immediate QIO review.

(6) The QIO must make a determination and notify the enrollee, the hospital, and the MA organization by close of business of the first working day after it receives all necessary information from the hospital, or the organization, or both.

(c) *Liability for hospital costs*—(1) *When the MA organization determines that hospital services are not, or are no longer, covered.* (i) Except as provided in paragraph (c)(1)(ii) of this section, if the MA organization authorized coverage of the inpatient admission directly or by delegation (or the admission constitutes emergency or urgently needed care, as described in §§ 422.2 and 422.112(c)), the organization continues to be financially responsible for the costs of the hospital stay when a timely appeal is filed under paragraph (a)(1) of this section until noon of the calendar day following the day the QIO notifies the enrollee of its review determination. If coverage of the hospital admission was never approved by the MA organization (or the admission does not constitute emergency or urgently needed care, as described in §§ 422.2 and 422.112(c)), the MA organization is liable for the hospital costs only if it is determined on appeal that the hospital stay should have been covered under the MA plan.

(ii) The hospital may not charge the MA organization (or the enrollee) if—

(A) It was the hospital (acting on behalf of the enrollee) that filed the request for immediate QIO review; and

(B) The QIO upholds the noncoverage determination made by the MA organization.

(2) *When the hospital determines that hospital services are no longer required.* If the hospital determines that inpatient

hospital services are no longer necessary, and the enrollee could not reasonably be expected to know that the services would not be covered, the hospital may not charge the enrollee for inpatient services received before noon of the calendar day following the day the QIO notifies the enrollee of its review determination.

[63 FR 35107, June 26, 1998; 63 FR 52614, Oct. 1, 1998, as amended at 70 FR 4740, Jan. 28, 2005; 70 FR 52027, Sept. 1, 2005]

§ 422.624 Notifying enrollees of termination of provider services.

(a) *Applicability.* (1) For purposes of §§ 422.624 and 422.626, the term provider includes home health agencies (HHAs), skilled nursing facilities (SNFs), and comprehensive outpatient rehabilitation facilities (CORFs).

(2) *Termination of service defined.* For purposes of this section and § 422.626, a termination of service is the discharge of an enrollee from covered provider services, or discontinuation of covered provider services, when the enrollee has been authorized by the MA organization, either directly or by delegation, to receive an ongoing course of treatment from that provider. Termination includes cessation of coverage at the end of a course of treatment preauthorized in a discrete increment, regardless of whether the enrollee agrees that such services should end.

(b) *Advance written notification of termination.* Prior to any termination of service, the provider of the service must deliver valid written notice to the enrollee of the MA organization's decision to terminate services. The provider must use a standardized notice, required by the Secretary, in accordance with the following procedures—

(1) *Timing of notice.* The provider must notify the enrollee of the MA organization's decision to terminate covered services no later than two days before the proposed end of the services. If the enrollee's services are expected to be fewer than two days in duration, the provider should notify the enrollee at the time of admission to the provider. If, in a non-institutional setting, the span of time between services exceeds two days, the notice should be given no later than the next to last time services are furnished.

(2) *Content of the notice.* The standardized termination notice must include the following information:

(i) The date that coverage of services ends.

(ii) The date that the enrollee's financial liability for continued services begins.

(iii) A description of the enrollee's right to a fast-track appeal under § 422.626, including information about how to contact an independent review entity (IRE), an enrollee's right (but not obligation) to submit evidence showing that services should continue, and the availability of other MA appeal procedures if the enrollee fails to meet the deadline for a fast-track IRE appeal.

(iv) The enrollee's right to receive detailed information in accordance with § 422.626 (e)(1) and (2).

(v) Any other information required by the Secretary.

(c) *When delivery of notice is valid.* Delivery of the termination notice is not valid unless—

(1) The enrollee (or the enrollee's authorized representative) has signed and dated the notice to indicate that he or she has received the notice and can comprehend its contents; and

(2) The notice is delivered in accordance with paragraph (b)(1) of this section and contains all the elements described in paragraph (b)(2) of this section.

(d) *Financial liability for failure to deliver valid notice.* An MA organization is financially liable for continued services until 2 days after the enrollee receives valid notice as specified under paragraph (c) of this section. An enrollee may waive continuation of services if he or she agrees with being discharged sooner than 2 days after receiving the notice.

EFFECTIVE DATE NOTE: At 68 FR 20349, Apr. 4, 2003, § 422.624 was added. This section contains information collection and recordkeeping requirements and will not become effective until approval has been given by the Office of Management and Budget